

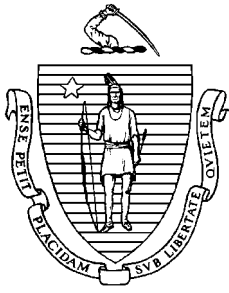
The Commonwealth of Massachusetts
Department of Public Health
Board of Registration of Nursing Home
Administrators
239 Causeway Street
Boston, MA 02114
617 - 727 - 4499
www.mass.gov/dph/boards

INSTRUCTIONS FOR ADMINSTRATOR IN TRAINING [AIT] APPLICATION

Please read these instructions thoroughly and carefully. All AIT supporting materials must be submitted at the same time in a large envelope. Incomplete AIT applications will be returned.

General Information: Candidates applying for approval of an AIT program must submit in writing to the Board the following documents:

1. The Administrator in Training (AIT) candidate must submit a request for the proposed AIT internship, including the name of the preceptor, the facility at which the training will take place and any requests for credit for academic and/or professional experience.
2. The preceptor must submit a letter to the Board requesting that they be approved as the preceptor. The preceptor must be a Massachusetts licensed administrator in good standing with at least five years of Nursing Home Administration experience.
3. A detailed outline of the proposed Internship must be submitted. [NOTE: the Preceptor Guidelines cannot be submitted as the internship outline.] Once approved, the preceptor must submit 3 and 6 months progress reports directly to the **Board of Registration of Nursing Home Administrators, Division of Health Professions Licensure, 239 Causeway Street, Boston, MA 02114.**
4. A signed agreement between the preceptor and the candidate. The agreement must state where the training is to be held, number of beds in the facility, and if it is a multi-level or skilled facility.
5. The Administrator in Training candidate must provide the Board with a current resume.
6. The Administrator in Training candidate must provide the Board with official transcript(s) in signed, sealed envelope[s].
7. The Board will notify AIT candidates if the proposed program is approved.
8. At the completion of the AIT program, the Preceptor must submit a final report to the Board for approval. When your AIT program has been completed and approved by the Board, you will be notified of the procedure for taking the licensure examination. You will also be notified to submit the **Administrator Affidavit Certificate of Internship Training** with your licensure application.
9. Retain a copy of the complete application package for your records.



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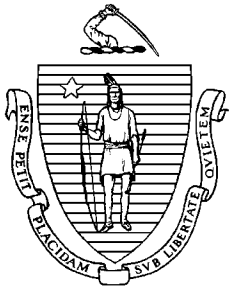
ADMINISTRATOR IN TRAINING [AIT] APPLICATION PACKET AND CHECKLIST

The application for the Administrator in Training [AIT] includes the following documents:

1. Application form
2. Preceptor Guidelines
3. Administrator Affidavit Certificate of internship Training [this form is submitted upon completion and approval of the AIT program by the Board]

The following must be included for a complete application. Please complete and enclose this checklist with your application. Incomplete applications will be RETURNED to you. Applications must be mailed to the above address in one envelope. Retain a copy of the complete application package for your records.

- _____ Application Form
- _____ Letter from the candidate to the Board requesting approval to be an AIT. This letter must include the name of the proposed preceptor, the facility where the AIT will take place and any requests for credit for academic and/or work experience.
- _____ Letter from Preceptor to Board requesting that he/she be approved as the preceptor. The preceptor must be a MA licensed administrator in good standing with at least five years of nursing home administrator experience.
- _____ Detailed outline of the proposed internship.
- _____ Letter of agreement between the candidate and the preceptor stating that they agree to the terms of the proposed internship.
- _____ Resume
- _____ Official transcripts [in signed, sealed envelopes].



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ADMINISTRATOR IN TRAINING (AIT)
APPLICATION

[PRINT OR TYPE, ANSWER ALL QUESTIONS]

1. Applicant Name: _____
Last First Middle
Maiden Name/Other Name: _____

2. Permanent Address: _____
No. Street Apt. #

City/Town State Zip Code

3. Business Address (If Applicable): _____
No. Street Apt. #

City/Town State Zip Code

4. Date of Birth: _____

5. Telephone Number-Day: _____ Evening: _____

8. Social Security Number (**Mandatory**): _____

Pursuant to MG.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax laws of the Commonwealth.

9. Educational Background:
Highest Relevant Degree: _____ Year: _____
Academic Major: _____
School Name: _____
School Location: _____

10. Professional Experience:
Number of Years of Paid Professional Practice: _____
Location of formal internship (if any): _____

11. List all professional licenses/certifications you have held in the United States, or any country or foreign jurisdiction, and the state/jurisdiction from which the license/certification was originally issued. Enclose a certificate of standing from each state or jurisdiction in which you have been licensed/certified, indicating the status of your license and any disciplinary information. Attach additional pages as necessary.

12. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐

If yes, please state the details (use a separate sheet if necessary): _____

13. Are you the subject of pending disciplinary actions by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐

If yes, please state the details (use a separate sheet if necessary): _____

14. Have you ever voluntarily surrendered or resigned a professional license to a licensing/certification board in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐

If yes, please state the details (use a separate sheet if necessary): _____

15. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐ If yes, please state the details (use a separate sheet if necessary): _____

16. Have you ever been convicted of a felony or misdemeanor in the United States or any country or foreign jurisdiction, other than a traffic violation for which a fine of less than \$200.00 was assessed? Yes: ☐ No: ☐ If yes, please state the details (use a separate sheet if necessary):

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that the failure to provide accurate information may be grounds for the Massachusetts Board of Registration of Nursing Home Administrators to deny me the right to sit as a candidate or to suspend or revoke a license issued to me in accordance with Massachusetts Law. I further attest that, pursuant to MG.L. c. 62C, s. 49A., to the best of my knowledge and belief, I have filed all Massachusetts tax returns and paid all Massachusetts taxes required by law.

Signature of applicant

Date

Notary Name (print)_____

Notary Signature_____ Commission expires_____

(Seal)

BOARD of REGISTRATION of NURSING HOME ADMINISTRATORS
Commonwealth of Massachusetts

PRECEPTOR GUIDELINES
Administrator in Training

I. GENERAL ADMINISTRATION SERVICES

Corporate Structure
Methods of Supervision
Pre-Admission and Admission of Patient
Business Correspondence
Employer-Employee Relations
State & Federal Regulation
Relationships with Dept. Of Public Welfare
Financial Records

V. SOCIAL SERVICES & CONSULTANT

Admission Procedures
Transfer Procedures
Discharge Procedures
Family Counseling
The Social Worker
The Physical Therapist
The Occupational Therapist
The Dietitian
The Pharmacist

II. NURSING

Knowledge of Nursing Functions
The Director of Nurses, RN's, LPN's & Aids
Physician Responsibilities
Tour of Stations
Medical Records
Drug Routines and Requirements

VI. PERSONNEL MANAGEMENT

Philosophy & Goals of Department
Personnel Policies, Procedures & Requirements
Counseling & Coordination
Problem Solving/Union Relations
Wages & Benefits

III. DIETARY

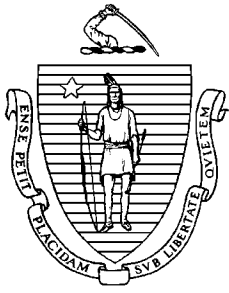
The Dietary Staff
Food Preparation & Services
Record Keeping
In-Service Education
Staff Meetings

VII. BUSINESS OFFICE

Methods of Bookkeeping
Billing Procedures
Payroll
Purchasing Procedures
Insurance Consideration
Medicare/Medicaid, Commercial, VA, private
sources of reimbursement and regulations
regarding each source

IV. HOUSEKEEPING, MAINTENANCE & LAUNDRY

Philosophy and Goals of Department
Administering Duties
Record Keeping
Inspections
Scheduling of Personnel
Cleaning and Maintenance Techniques



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ADMINISTRATOR AFFIDAVIT CERTIFICATE OF INTERNSHIP TRAINING

(Trainee Name) (Degree Level)

I, _____, _____, hereby certify
(Administrator) (License number)

that the trainee named above has trained in the _____
(Name of Nursing Home)

_____, from _____ to _____, working
(mm/dd/yyyy) (mm/dd/yyyy)

_____ hours per week, for a total of _____ hours.

During this training period, the trainee named above, has worked exclusively as an Administrator In Training and has not simultaneously held any other position in this facility. During the course of this training, the trainee was exposed to all aspects of nursing home management and the operation of the named facility, including the following: admittance procedures, patient care policies, utilization review processes, in-service training procedures, social services, medical records, housekeeping and sanitation, dietary and kitchen operations, medical department and applicable rehabilitation procedures, laundry services, purchasing procedures, personnel department procedures and policies, management functions including budgeting, billing, accounts receivable and payable, and departmental scheduling, etc.

I have been licensed in good standing for a least five years.

Under the penalty of perjury, this affidavit has been signed after the completion date of the AIT.

Signature of Administrator Date

Notary Public Notary Expiration Date

Effective Date of This Document Seal